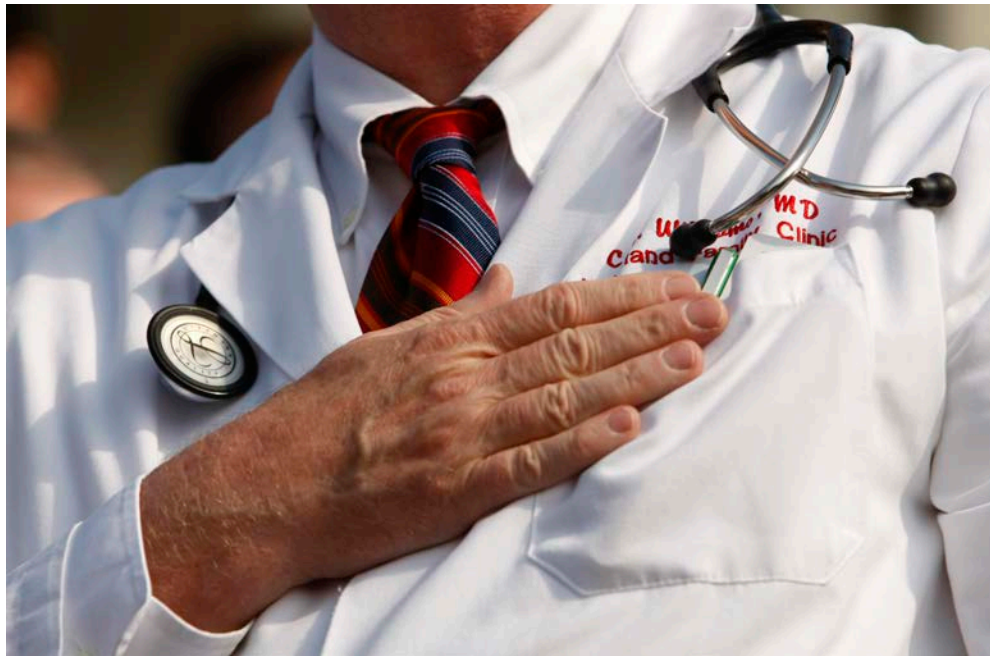




February 23, 2012



Reuters

**Health Care Providers' Consciences and Patients' Needs:
The Quest for Balance**

William A. Galston and Melissa Rogers

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Consider two recent controversies.

In September of 2011, the University of Medicine and Dentistry of New Jersey announced that all nurses employed in the hospital it runs would have to help with abortion patients before and after the procedure, “reversing a long-standing policy exempting employees who refuse based on religious or moral objections.”¹ In October, a group of objecting nurses filed a federal lawsuit. In November, U.S. District Judge Jose Linares granted a request for a temporary restraining order barring the hospital from requiring the objecting nurses to undergo any “training, procedures or performances relating to abortions...”² In December, the hospital backed down, agreeing that nurses with conscientious objections would not have to assist with pre- or post-operative care for abortions except when the mother’s life is threatened and no other non-objecting staff are available to assist. The presiding judge made it clear that the parties would be back in court if they violated either the letter or spirit of the agreement.³



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On January 20, 2012, the Department of Health and Human Services (HHS) announced a final rule specifying preventive health services that most new insurance plans would be required to cover under the Affordable Care Act.⁴ Contraceptives and sterilizations were listed as required services, including drugs like Plan B and Ella but not RU-486. HHS provided a narrow exemption from this rule for certain religious entities like churches, but this exemption did not exempt most religiously affiliated universities, hospitals and social service agencies. HHS said religiously affiliated groups that do not already provide such coverage would have an additional year, until August 1, 2013, to comply with the new mandate. In the meantime, HHS explained, these employers would have to disclose the fact that they do not offer such coverage and tell employees that affordable contraceptive services can be found at sites such as community health centers, public clinics, and hospitals.

Cardinal Timothy Dolan, president of the United States Conference of Catholic Bishops, swiftly condemned this decision. “Never before has the federal government forced individuals and organizations to go out into the marketplace and buy a product that violates their conscience,” Dolan said. “This shouldn’t

¹ Rob Stein, “New Jersey Nurses Charge Religious Discrimination over Hospital Abortion Policy,” *The Washington Post*, November 27, 2011.

² *Danquah v. University of Medicine and Dentistry*, Temporary Restraining Order (November 3, 2011) at <http://www.adfmedia.org/files/DanquahTRO.pdf>

³ *Danquah v. University of Medicine and Dentistry*, Transcript of Proceedings (December 22, 2011) at <http://www.adfmedia.org/files/DanquahSettlementTranscripts.pdf> Other court documents and briefs in this case may be found at <http://www.adfmedia.org/News/PRDetail/5176>

⁴ Department of Health and Human Services, “A Statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius” (January 20, 2012) at <http://www.hhs.gov/news/press/2012pres/01/20120120a.html>

happen in a land where free exercise of religion ranks first in the Bill of Rights.”⁵ John Garvey, president of the Catholic University of America, argued that the mandate “requires us to contradict in our actions the very lessons that we’re teaching with our words in classes and in our daily activities at the university. It makes us hypocrites in front of the students that we’re trying to educate.”⁶

Following the announcement of the final rule, Catholic priests across the country read letters to their congregants protesting the mandate.⁷ Members of Congress filed bills, some of which are designed to broaden the exemption and others of which are aimed at undoing the mandate entirely. Lawsuits that had been filed earlier against the administration gathered support,⁸ and the controversy became an issue in the 2012 presidential race, with certain Republican candidates charging that the final rule was evidence of a “war on religion” by the Obama administration.

For their part, reproductive rights groups praised the decision by Secretary of Health and Human Services Kathleen Sebelius to refuse to provide a broader exemption, even as they noted their disagreement with the exemption for churches, claiming it lacked congressional authorization.⁹ The National Women’s Law Center (NWLC) described the final rule as “a major milestone in protecting women’s health. Contraception is critical preventive health care and its use among women of child-bearing age is nearly universal.”¹⁰ Planned Parenthood argued that “all women, regardless of their employer, should be able to access the birth control coverage benefit,” adding that it disagreed with the decision to delay the application of the rule to certain religiously affiliated organizations.¹¹

⁵ United States Conference of Catholic Bishops, “Bishops Vow to Fight Coercive HHS Mandate,” at <http://usccb.org/issues-and-action/religious-liberty/conscience-protection/index.cfm>

⁶ PBS, “Obama Administration, Catholic Leaders Clash Over Contraception Mandate” (February 6, 2012) at http://www.pbs.org/newshour/bb/religion/jan-june12/catholics_02-06.html

⁷ Rick Jervis, “Catholics blast federal birth control mandate,” *USA Today* (January 30, 2012) at <http://www.usatoday.com/news/religion/story/2012-01-29/catholic-birth-control-protest/52874660/1>

⁸ On November 10, 2011, Belmont Abbey College sued the federal government to block the application of this rule to the college. See Adelle M. Banks, *Catholic College Sues Over Contraception Mandate*, Religion News Service, (November 11, 2011) at http://www.washingtonpost.com/national/on-faith/catholic-college-sues-over-contraception-mandate/2011/11/11/gIQA7uasCN_story.html

For a copy of the complaint, click here: <http://www.becketfund.org/belmont-abbey-college-sues-the-federal-government-over-new-obamacare-mandate/>

⁹ J. Lester Feder, “Contraceptive Rule a Pill for Obama,” *Politico*, December 7, 2011 at <http://www.politico.com/news/stories/1211/70036.html>

¹⁰ National Women’s Law Center, “HHS Decision on Contraceptive Coverage a Major Milestone” (January 20, 2012) at <http://www.nwlc.org/press-release/hhs-decision-contraceptive-coverage-important-milestone>

¹¹ Planned Parenthood Federation, “Planned Parenthood Applauds HHS for Ensuring Access to Affordable Birth Control” (January 20, 2012) at <http://www.plannedparenthood.org/about->

In its defense of the mandate, the White House said it would provide needed services to Americans no matter where they worked.¹² The administration also pledged to work with religious groups during the additional year to address their concerns.¹³ “The Obama Administration is committed to both respecting religious beliefs and increasing access to important preventive services,” Domestic Policy Director Cecilia Muñoz said.¹⁴

On February 10, 2012, however, President Barack Obama announced an “accommodation” of religious objections to the provision of certain health care services. The president said religiously affiliated hospitals, universities, and social service agencies also would not be required to provide coverage for contraceptive services if they object for religious reasons, but such coverage would be extended to employees of objecting organizations nonetheless. President Obama explained:

[R]eligious organizations won’t have to pay for [contraceptive services that are objectionable to them for religious reasons], and no religious institution will have to provide these services directly. Let me repeat: These employers will not have to pay for, or provide, contraceptive services. But women who work at these institutions will have access to free contraceptive services, just like other women, and they’ll no longer have to pay hundreds of dollars a year that could go towards paying the rent or buying groceries.¹⁵

More specifically, the Obama administration said that insurance companies will be required to cover contraception if the religious organization chooses not to do so. Thus, objecting religious organizations will not have to provide these benefits or refer employees to others to receive them. Instead, the insurance companies of objecting religious employers will contact employees directly. The insurer will offer these benefits to employees separately from the insurer’s agreement with the objecting religious employer. The White House also said insurance companies will be required to provide these benefits free of charge. According to the administration, “[c]overing contraception is cost neutral since it saves money by

us/newsroom/press-releases/planned-parenthood-applauds-hhs-ensuring-access-affordable-birth-control-38582.htm

¹² Cecilia Muñoz, *Health Reform, Preventive Services, and Religious Institutions* (February 1, 2012) at <http://www.whitehouse.gov/blog/2012/02/01/health-reform-preventive-services-and-religious-institutions>.

¹³ Press Briefing by Press Secretary Jay Carney (February 6, 2012) at <http://www.whitehouse.gov/the-press-office/2012/02/06/press-briefing-press-secretary-jay-carney-262012>.

¹⁴ Cecilia Muñoz, *Health Reform, Preventive Services, and Religious Institutions* (February 1, 2012).

¹⁵ Remarks by President Barack Obama on Preventive Care (February 10, 2012) at <http://www.whitehouse.gov/photos-and-video/video/2012/02/10/president-obama-speaks-contraception-and-religious-institutions#transcript>

keeping women healthy and preventing spending on other health services.”¹⁶ Insurance companies will not be permitted to increase the premiums of objecting religious employers to cover the cost of contraceptive coverage, White House officials said.¹⁷

An accompanying White House fact sheet said a final rule on the matter would be released on February 10, but it also said that document would describe an upcoming rulemaking that would memorialize President Obama’s accommodation. The administration published this document later on February 10.¹⁸ “These regulations finalize, without change, the interim final regulations” with the narrow exemption, the document states. At the same time, it also provides: “Before the end of the temporary enforcement safe harbor, the Departments will work with stakeholders to develop alternative ways of providing contraceptive coverage without cost sharing with respect to non-exempted, non-profit organizations with religious objections to such coverage.” In this document, the agencies also say they “intend to develop policies to achieve the same goals for self-insured group health plans sponsored by non-exempted, non-profit religious organizations with religious objections to contraceptive coverage.”¹⁹

A number of religious leaders, including some prominent Catholic leaders, welcomed this accommodation as a workable plan that helpfully addresses religious liberty concerns.²⁰ For example, the Catholic Health Association said it was “very pleased with the White House announcement,”²¹ and that it “look[ed] forward to reviewing the specifics of the changes in the mandated benefits.”²² The Association

¹⁶ White House, “FACT SHEET: Women’s Preventive Services and Religious Institutions” (February 10, 2012) at <http://www.whitehouse.gov/the-press-office/2012/02/10/fact-sheet-women-s-preventive-services-and-religious-institutions>

¹⁷ Tracie Mauriello and Ann Rodgers, *White House Revises on Insurance Mandate for Contraception* Pittsburgh Post-Gazette (February 10, 2012) at <http://www.post-gazette.com/pg/12041/1209361-100.stm?cmpid=latest.xml#ixzz1mD6To9eb>

¹⁸ Departments of the Treasury, Labor and Health and Human Services, *Final Rules on Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act* (February 10, 2012) at

<http://www.gpo.gov/fdsys/pkg/FR-2012-02-15/pdf/2012-3547.pdf>

¹⁹ *Id.*

²⁰ A co-author of this report also welcomed this accommodation and encouraged its careful implementation. See Melissa Rogers, *President Obama’s Contraceptive Solution*, The Brookings Institution (February 10, 2012) at

http://www.brookings.edu/opinions/2012/0210_obama_catholic_rogers.aspx; and Melissa Rogers, *Honoring Religious Objections and Access to Contraceptive Coverage*, The Brookings Institution (February 17, 2012) at http://www.brookings.edu/opinions/2012/0217_religion_obama_rogers.aspx

²¹ Catholic Health Association is Very Pleased with Today’s White House Resolution that Protects Religious Liberty and Conscience Rights (February 10, 2012) at http://www.chausa.org/Pages/Newsroom/Releases/2012/Catholic_Health_Association_is_Very_Pleased_with_Todays_White_House_Resolution_that_Protects_Religious_Liberty_and_Conscience_Rights/

²² Catholic Health Association Will Review the Proposed New Rules for the HHS Mandate (February 13, 2012) at http://www.chausa.org/Pages/About_CHA/Presidents_Page/HHS_Mandate/

of Jesuit Colleges & Universities “commend[ed] the Obama administration for its willingness to work with us on moving toward a solution,” and said it “look[ed] forward to working out the details of these new regulations with the White House.”²³ An interfaith group of leaders hailed the accommodation as “a major victory for religious liberty and women’s health.”²⁴

The United States Conference of Catholic Bishops initially called the plan “a first step in the right direction” that needed careful review,²⁵ but condemned it after engaging in that review.²⁶ Hundreds of academics and religious leaders also rejected the accommodation, deeming it “unacceptable.”²⁷ These leaders argued that the policy would still require religious institutions and individuals to purchase insurance policies that would include objectionable services, and that the costs of contraceptive coverage would not be free but rather would be passed on to objecting religious institutions through higher premiums. The Catholic Conference also raised concerns about religious insurers that would object to providing coverage for contraceptive and sterilization services. Further, the Conference argued that any employer with religious or moral reservations should be able to refuse to pay for and provide this coverage. President Obama’s “proposal continues to involve needless government intrusion in the internal governance of religious institutions, and to threaten government coercion of religious people and groups to violate their most deeply held convictions,” the Conference said. According to the Catholic Bishops, “[t]he only complete solution to this religious liberty problem is for HHS to rescind the mandate of these objectionable services.”²⁸ Opponents of the accommodation also bitterly criticized the administration’s decision to issue a final rule with the narrow exemption while promising a future rulemaking to implement President Obama’s accommodation.²⁹

That these two controversies raise fundamental—and politically consequential—questions is obvious. But they take place against a backdrop of longstanding tensions between claims of conscience and laws of broad scope and application—

²³ *Association of Jesuit Colleges & Universities Statement on Change to HHS Mandate for Religious Institutions* (February 10, 2012) at <http://www.ajcunet.edu/AJCU-Statement-on-HHS-Ruling>.

²⁴ *Prominent National Faith Leaders Celebrate White House’s Common-Ground Solution on Contraceptive Coverage* (February 10, 2012) at <http://www.faithinpubliclife.org/newsroom/press/consciencerelease/>

²⁵ United States Conference of Catholic Bishops, *Bishops Studying Initial White House Movement on Religious Liberty* (February 10, 2012) at <http://usccb.org/news/2012/12-025.cfm>

²⁶ *Bishops Renew Call to Legislative Action on Religious Liberty* (February 10, 2012) at <http://usccb.org/issues-and-action/religious-liberty/conscience-protection/bishops-renew-call-to-legislative-action-on-religious-liberty.cfm>

²⁷ *Unacceptable* (February 15, 2012) at <http://www.becketfund.org/unacceptable-2/>.

²⁸ *Bishops Renew Call to Legislative Action on Religious Liberty* (February 10, 2012) at <http://usccb.org/issues-and-action/religious-liberty/conscience-protection/bishops-renew-call-to-legislative-action-on-religious-liberty.cfm>

²⁹ See, for example, *Six More Things Everyone Should Know About the HHS Mandate* (February 13, 2012) at <http://usccbmedia.blogspot.com/2012/02/six-more-things-everyone-should-know.html>

tensions well-known to experts but less so to public officials and most citizens. Knowing that the implementation of federal health care reform was bound to expose these tensions, the Brookings Project on Religion, Policy and Politics convened a day-long, off-the-record consultation in June 2011 (participants are quoted herein only by specific permission) involving theologians, moral philosophers, legal scholars, health practitioners, and advocates reflecting perspectives on all sides of these issues. This report is informed by that discussion as well as research the co-authors independently conducted. It is not an attempt to reflect a group consensus on these issues. The report sets forth the thoughts and conclusions of the authors.

While the co-authors are under no illusion that this or any report could settle controversies that have been raging for centuries, we hope that it can contribute to a better informed and more open-minded discussion about how to proceed. Although there is no way of resolving clashes over first principles, we believe that good will on all sides can often open a path to balanced approaches that respect and, to the greatest extent possible, accommodate competing claims.

We are grateful to the Ford Foundation for its generous support of the Project on Religion, Policy and Politics, which has made this consultation and report possible.

PART ONE: CONSCIENCE IN GENERAL

Conscience in religion and philosophy

Conscience is generally regarded as an inner state or faculty linked to an awareness of moral limits and to the ability to distinguish right from wrong. Different faiths and philosophical creeds offer varying accounts of the source of conscience—reason, natural law, community, God’s law, or an unmediated encounter with the divine. But they agree that conscience is something individuals experience and invoke as a source of moral guidance. This is not to say that a group, even one as large as a nation, may not have similar conscientious reactions to shared experiences (Germany after World War II is an example of this). Still, conscience is collective only by analogy. Many traditions, moreover, see conscience as the source of the discomfort we feel when we act in ways that we know we should not and of the self-criticism that attends the violation of obligations or commands. But conscience is not merely negative. For three millennia, philosophers as well as pious believers have cited conscience as a source of affirmative obligations as well.

Beyond these broad commonalities, faith traditions offer divergent accounts of conscience. For Catholics, conscience is a faculty for the apprehension of practical

truth, including the core propositions of natural law. Because all human beings are endowed with this faculty and because practical truth is one and the same for everyone everywhere, conscience in principle tends toward agreement. Catholic thinkers thus encounter two challenges—accounting for legitimate conscientious disagreement, and offering principled grounds for respecting the outcome of conscientious but erring moral reflection.

Some moral disagreement stems from distortions external to moral reflection rightly understood—from self-interest, passion, or willful disregard of considerations relevant to moral judgment. But not all disagreement is the product of such distortion. Practical reasoning involves not only the major premises that natural law principles supply, but also minor premises drawn from actual social conditions and personal circumstances. So legitimate moral disagreement can arise when individuals differ in their assessment of facts on the ground, or concerning the impact of specific proposals on these facts. During the debate over welfare reform in the mid-1990s, the late Senator Daniel Patrick Moynihan delivered an impassioned speech denouncing the legislation then on the floor, the enactment of which, he declared, would condemn a million children to a life of homelessness “sleeping on heating grates.” If this had turned out to be the case, it would have represented a decisive moral argument against passing the bill. Although the bill became law, it did not lead to the horrendous consequences Moynihan feared. He was wrong, conscientiously wrong, in a manner worthy of respect.

There is another, even more fundamental source of legitimate conscientious disagreement. Contemporary theorists have argued that natural law offers a multiplicity of principles, each of which constitutes a defensible aim of action, and that these principles do not come packaged in a neat hierarchy. If, as is typically the case, a moral choice brings more than one such principle into play, it is not always clear how they are to be balanced, or which should enjoy priority over the others. And individuals can conscientiously disagree as to how this should be done.³⁰

These cases offer clear examples of moral differences that merit neither disapproval nor suppression. But there are good reasons for broadening further the range of tolerable if not commendable disagreements. It is valuable for individuals to recognize and correct their mistakes through internal processes of self-criticism and moral growth, processes that external coercion can thwart. The tranquility and good order of the community, moreover, may require more scope for disagreement than the merits of particular views might otherwise suggest.

³⁰ For a well-known discussion of these issues, see John Finnis, *Natural Law and Natural Rights* (New York: Oxford University Press, 1980).

While differences among Protestant denominations are significant, one may hazard some generalizations. Protestants are less likely than Catholics to see conscience in close relation to natural law, or indeed to reason. We know only what God's grace allows, and human beings experience that grace in different ways. To be sure, for many Protestants, shared communal understandings shape the development and content of conscience. Still, conscience has a subjective as well as objective component, based on what one leading Protestant theologian calls the "free personal center" that each individual possesses. This freedom contributes to the "last best judgment" in moral matters—our resting-point after inquiry and reflection—that many Protestants and secular thinkers see as the manifestation of conscience in action. Conversely, there is an obvious objection to situating conscience too comfortably within communities (even faith communities): because individual conscience may require standing up to majorities or authorities within one's community of origin, any viable account of conscience must make room for a locus of moral judgment not reducible to communal norms.

While the scope of individual freedom is unclear, it includes at the very least our various understandings of the modes of worship and other duties individuals owe to God. As James Madison put it in his *Memorial and Remonstrance Against Religious Assessments*, "It is the duty of every man to render to the Creator such homage, and such only, as he believes to be acceptable to him."

This duty has two key political implications. It is the basis of a right of religious liberty—an inalienable right—that every individual may rightly claim against all others. As such, it limits the legitimate purview of legislative majorities. Further, our duties to God take priority over the claims of civil society and serve as reservations against civil authority. The Protestant conception of conscience thus establishes a basis for conscientious objections to laws and regulations that individuals regard as going beyond appropriate bounds, and also for demands that civil authorities "accommodate" what conscience dictates.

By contrast, the idea of conscience does not fit comfortably into a Jewish framework, the principal focus of which is law. It would be caricature to suggest that Judaism lacks an awareness of or concern for the domain of individual inwardness. Indeed, there are long-standing tensions between legalists and advocates of increased attention to inward spirituality and feeling. But Jews tend not to see inwardness as the basis of special individual insight into the duties we owe to God or to one another. The emphasis is on *orthopraxy* rather than *orthodoxy*, so much so that Maimonides' effort to lay down a core of mandatory beliefs—a creed—set off a controversy within Judaism that has raged for nearly a millennium.

Jews took it for granted that Jewish authorities should govern according to Jewish law (*halacha*). To the extent that authorities did so, there could be no conflict between civil dictates and religious requirements. But for nearly two thousand

years, every Jew lived under non-Jewish authorities. The *halacha* responded by establishing a strong presumption in favor of obeying duly constituted authority, whatever form it might take. The operative principle was *dina d'malchuta dina*: the law of the (secular) kingdom is law.

Still, this presumption had limits. Jews were forbidden to obey three legal commands—to commit murder, incest, or idolatry—and to pay for their disobedience with their lives if necessary. (Martyrdom for these three causes—and for them only—is called “sanctifying God’s name.”) Jews resisted and then revolted when Hellenistic rulers ordered them to bow down before Greek gods, and some of the most famous rabbis were executed by the Romans after rejecting orders to cease teaching Jewish law to their students. While these episodes resemble conscientious refusal, they had nothing to do with an individual inner sense of right and wrong. They were rooted, rather, in legal norms known to most Jews and binding on all.

It would be misleading to stop at this point, however. While the *halacha* took the written Torah—the five books of Moses—as its point of departure, it developed through centuries of interpretation that were eventually organized and summarized in the Talmud. This process of interpretation is every bit as complex and controversial as are the interpretive practices the U.S. Supreme Court employs. Some rabbis took the view that norms of morality, humanity, and simple decency could be known outside the law and served as free-standing constraints on interpretive conclusions. For example, while the written Torah prescribed the death penalty for a considerable range of offenses, the rabbis reinterpreted courts’ procedural requirements to rule it out in many of these cases.

One might say that the human capacity to grasp law-shaping moral norms—a capacity some Talmudic scholars reject in principle—would be the Jewish equivalent of conscience. And there is another possible Jewish analogy to conscience. Some contemporary scholars argue that Judaism contains a version of natural law—namely, the covenant that God made with Noah. Through reason and experience, all human beings, not just Jews, could apprehend the terms of this covenant. To be “god-fearing” was to regard these terms as the basis for judging, and when necessary resisting, the demands of civil authorities. The Egyptian midwives were god-fearing because they resisted carrying out Pharaoh’s murderous orders.

The location of conscience in an inner domain raises questions about its relation to the world of individual action and social relations. Is this realm of inwardness open to coercion, even in principle? John Locke famously answered in the negative. Both faith and conscience, he declared, consist in the “inward persuasion of the mind. . . . And such is the nature of the understanding, that it cannot be compelled to the belief of anything by outward force.” Martin Luther took a similar position. But Jonas Proast, Locke’s persistent antagonist, offered a counter-argument that

many contemporary commentators regard as persuasive. So did Edmund Burke. If conscience is more than an “inner light,” if it is shaped to some extent by community norms and public law, then it is hard to maintain the view that it is an inner citadel sealed off from the world. On the other hand, some individuals display an unusual capacity to stand apart from community and polity when they judge that circumstances require such distancing, a moral potential that no acceptable account of conscience can deny.

Although conscience is closely linked to at least some religions (placing non-western and non-theistic faiths within a Christian template raises complex interpretive issues), it is found within secular contexts as well. Among philosophical traditions, Greek and Roman Stoicism and Immanuel Kant’s practical philosophy offer especially well-developed understandings. For Kant, conscience is rooted in our awareness of the inner freedom that gives us our inalienable capacity for moral agency. Even when we act so as to degrade others or ourselves, we can never expunge our ability to judge the wrong we have committed and to act rightly in the future.

Secular conscience manifests itself in professional contexts as well. Becoming a physician means entering into a dense network of moral responsibilities to one’s patients and society. At times this creed sets physicians in opposition to medical authorities and even the law of the state. Norms of doctor-patient confidentiality can collide with the requirements of legal proceedings, and the law does not always exempt from disclosure communications that professionals and their clients regard as private and privileged. Similar issues arise in journalism: from time to time, reporters go to jail rather than reveal the names of sources to whom they have promised confidentiality.

Conscience in U.S. constitutional history

There is no guarantee that any nation’s legal structure will reflect the core claims of conscience. In this respect, among others, U.S. constitutional history is fraught with ambiguity. Madison’s original draft of what became the First Amendment would have protected “the full and equal rights of conscience.” By the close of the House debate, the language included protections for both the free exercise of religion and rights of conscience, implying a distinction between them. After moving back and forth between these two formulations, the Senate ultimately selected religious free exercise, which became the language sent to the states for ratification.

On its face, as Michael McConnell has observed, this legislative history points unequivocally toward a single interpretation of the constitutional language. Either the framers viewed conscience and religion as coextensive, or they saw them as different but opted to protect religion rather than conscience. In either case, claims of conscience lacking a religious basis would fall outside the realm of constitutional protection.

If religious but not secular claims of conscience are potentially eligible for constitutional protection, then legislators and courts have no choice but to reach the question of what religion is and what distinguishes it from other comprehensive world views. Given America's religious demography during the founding period, it would be natural for the framers to regard belief in a "creator"—the source of transcendent rights and duties—as the defining and distinguishing feature of religion. But as the makeup of America's population has become more diverse, especially in recent decades, pressure on that definition has intensified. Can the law really draw a bright-line distinction between Christianity, Judaism and Islam, on the one hand, and Buddhism, Taoism and Confucianism on the other? Or would doing so eviscerate the robust religious freedom promised by the First Amendment?

It might seem more defensible to distinguish between world views based exclusively on reason and experience, and those relying on revelation or a direct relationship with the divine. But complications abound here as well. After all, no less authoritative document than the Declaration of Independence characterizes certain truths as "self-evident," including the "Laws of Nature and of Nature's God," which the document proceeds to spell out with considerable particularity. So while the Declaration has an unmistakably theological foundation, which some scholars characterize as Deist rather than specifically Christian, its foundational truths are in principle equally accessible to the reason of all human beings, regardless of other creedal differences. In practice, how can the law distinguish between this religion of reason and other comprehensive views, such as Kantianism, that claim an exclusively rational foundation for binding duties? If we say that the Declaration's rational religion includes a "creator" in distinction to other reason-based views, we have returned to the problem of excluding non-western creedal communities from the ambit of the Constitution.

In the end, then, it is not surprising that U.S. Supreme Court interpretation moved in a more capacious direction. As early as World War I, The American Civil Liberties Union unsuccessfully brought suit on behalf of individuals who conscientiously objected to military service on moral rather than religious grounds. Nearly half a century later, during the Vietnam Era, this broader view prevailed. Section 6(j) of the Universal Military Training and Service Act invoked the traditional view by making draft exemptions available to those who were conscientiously opposed to military service by reason of "religious training and belief." The Act proceeded to define the required religious conviction as "an individual's belief in a relation to a Supreme Being involving duties superior to those arising from any human relation, but [not including] essentially political, sociological, or philosophical views or a merely personal moral code." In *United States v. Seeger* (1965), however, the Supreme Court broadened the statutory definition by interpreting the Act to include a "sincere and meaningful belief which occupies in the life of the possessor a place parallel to that filled by the God of those admittedly qualifying for the exemption." Five years later, in *Welsh v. United States*, the Court further expanded the reach of the statute to include explicitly secular beliefs that "play the role of a religion and

function as a religion in life.” Thus, exemptions could be extended to “those whose consciences, spurred by deeply held moral, ethical, or religious beliefs, would give them no rest or peace if they allowed themselves to become part of an instrument [of war].” Through a process of statutory interpretation, the Court gave force to an understanding of conscience that the framers of the First Amendment did not contemplate, or rejected outright. (This did not end the judicial search for a definition of religion under the First Amendment, however.)

There is a further complication: within the military context, there is a distinction between comprehensive and selective conscientious objectors. The former oppose all wars, while the latter differentiate between just and unjust wars. Invoking the principles of just war theory, which initially claimed religious foundations, selective objectors can say that a particular war is unjustified because it represents an act of aggression rather than self-defense. Or they can say that while the war is justified in principle, it is being conducted unjustly—for example, by targeting civilians in violation of the principle of noncombatant immunity. The difficulty is that just war theory includes criteria, such as proportionality of means to ends, whose application verges on the types of contestable practical judgments that fall within the purview of political authorities. If conscience is extended too far, it becomes indistinguishable from political decision-making. And it is hard to argue that each individual may judge such matters for him/herself in the face of duly enacted democratic legislation to the contrary—unless one is willing to embrace principled anarchy. “Conscience” must be defined and applied as a check on majorities, not as a substitute for collective decision-making.

A final complication: Whatever else it may be, conscience is undoubtedly an inner state of belief and motivation, while law is most at home defining and judging actions. Any attempt to assess the sincerity of belief entangles courts in inquiries that could be viewed as invading freedom of conscience itself. The counterargument is that those who invoke conscientious objections to otherwise valid laws voluntarily open themselves to these inquiries. The reasoning is straightforward: because law typically restricts choice and requires us to do things we would prefer not to, we are all motivated to escape its burdens. Unless courts can investigate our motives for claiming exemptions, everyone could mouth the language of legally recognized exemptions, and laws would become unenforceable. Still, such inquiries are complex and perilous. The external indicia of sincerity are less than reliable. And if courts try to reason from the sincerity of the believer to the credibility of the belief, many religions would fail the test. By definition, all miracles defy the laws of nature, and it is hard to see what makes one purported miracle more or less credible than the next. Surely courts cannot “grandfather” religions whose miracles have been long and widely accepted while subjecting newer faiths to stricter scrutiny. Indeed, the Court has said “[t]he determination of what is a ‘religious’ belief or practice is more often than not a difficult and delicate task,” but “the resolution of that question is not to turn upon a judicial perception of the particular belief or practice in question; religious beliefs need not be acceptable,

logical, consistent, or comprehensible to others in order to merit First Amendment protection.”³¹

Difficulties such as these have led some jurists to question the entire enterprise of extending religion- or conscience-based exemptions and accommodations from generally valid statutes. In *Employment Division v. Smith*, the Court rejected the claims of individuals who invoked the Native American practice of sacramental peyote-smoking as a defense against Oregon’s controlled substances law.³² The Court considered whether the Constitution permits the State of Oregon to deny unemployment benefits to persons fired from their jobs because of religiously inspired use of peyote. Its answer was “yes.” The Court deemed the law at issue to be neutral toward religion and generally applicable. Thus, it said, there was no need to provide exemptions from the law for religiously motivated conduct. The majority declared that “Any society adopting such a system would be courting anarchy” and that this danger “increases in direct proportion to the society’s diversity of religious beliefs and its determination to coerce or suppress none of them.” Within very broad limits, legislators are free to enact such exemptions and accommodations as they see fit. But individuals may not claim them as a matter of right under the First Amendment. The majority acknowledged the risks their holding entailed: “It may fairly be said that leaving accommodation to the political process will place at a relative disadvantage those religious practices that are not widely engaged in.” But this outcome represents the lesser evil, the Court said, and “must be preferred to a system in which each conscience is a law unto itself . . .”

Smith proved to be one of the most unpopular decisions the modern Supreme Court has ever handed down. An aroused religious and civil liberties community backed by organizations across the ideological spectrum came together to draft and lobby for the Religious Freedom Restoration Act (RFRA), which passed the House unanimously and the Senate by a vote of 97 to 3. President Bill Clinton signed it into law in the fall of 1993.

RFRA sought to restore the constitutional understanding of free exercise that prevailed before *Smith*: the law should not substantially burden the free exercise of religion unless the government can demonstrate that it does so in furtherance of a compelling interest, and with the least intrusive and restrictive means that effectively promote that interest. The Supreme Court subsequently struck down RFRA as applied to the states³³ but has continued to apply it to the activities of the federal government.³⁴

³¹ *Thomas v. Review Bd.*, 450 U.S. 707, 714 (1981)(citations omitted).

³² *Employment Division v. Smith*, 494 U.S. 872 (1990).

³³ *City of Boerne v. Flores*, 521 U.S. 507 (1997).

³⁴ *See Gonzales v. O Centro Espirita*, 546 U.S. 418 (2006) and *Cutter v. Wilkinson*, 544 U.S. 709 (2005).

General considerations

For moral or religious reasons, some health care providers object to providing certain medical services. The classic case is a physician who refuses to perform an abortion, but that is far from the only one. Some nurses, hospital orderlies, medical administrative staff, emergency medical technicians, and pharmacists have been unwilling to assist in the provision of particular health care services, and objections have been raised not only about abortions but also about contraceptives, sterilizations, assisted suicide, reproductive technology, blood transfusions, and stem-cell research.

Some health care institutions have raised similar objections, citing the convictions of the religious communities sponsoring them. Hospitals have refused to provide abortions and sterilizations, pharmacies have declined to stock items like emergency contraception, and employers have objected to mandates requiring their health plans to cover the costs of employees' prescription contraceptives.

Who should be permitted to refuse to provide, assist, or pay for services in these situations? Should objections to any service be honored, or only acts the objector would view as the taking of human life? What institutions, if any, should be permitted to refuse to offer particular health care services? What about the competing interest of access to health care, including the claims of those who say they seek and provide health care services as a matter of conscience? Can these competing interests be harmonized, at least at times, or must one always trump the other? What is current law and policy on these issues? What should it be?

We turn now to these issues. To set the stage for this discussion, we first touch on the nature of the health care profession and conscientious objections within that context.

Health care professionals and institutions have traditionally had a great deal of freedom to refuse to perform particular services and take certain patients. According to bioethicist Holly Fernandez Lynch, "Existing case law and statements of professional ethics convey the well-established rule that initiation of the physician-patient relationship is entirely voluntary for both parties. Physicians are

free to refuse to accept a prospective patient for any reason not prohibited by law or contract, such as discriminatory bases for refusal.”³⁵

Once physicians have entered into relationships with patients, they are expected to act in the patients’ best interests. That does not necessarily mean they are required to do whatever the patient asks, however. Doctors exercise professional judgment in caring for and serving patients, including judgments about ethical matters.

Likewise, doctors generally may choose to specialize in some areas and not others and to limit their practices so that they perform some procedures and not others. For example, a physician may choose to practice gynecology and not obstetrics.

Hospitals and other health care institutions typically enjoy similar latitude. As Columbia University Law School Professor Kent Greenawalt has explained: “If we put aside life-saving medical procedures and avoidance of medical malpractice (as performing some operations without blood transfusions), hospitals can commonly decline to perform operations private patients might desire, including abortions, sterilizations, and elective plastic surgery.”³⁶

Put simply, the freedom to form patient relationships and to choose which services to offer is “the norm in the health care setting.”³⁷ Thus, when individuals and institutions refuse to provide certain services for moral or religious reasons, it is often understood as an acceptable and unremarkable feature of this system.

At the same time, state licensing of health care professionals and institutions to provide services that are essential to human health creates ethical as well as legal responsibilities. Through such licensing, the government gives these individuals and institutions an exclusive right to offer health care services. No one argues that this monopoly requires every doctor and every hospital to offer all health care services. But most agree it creates some obligation for the health care profession to ensure that needed services are provided to patients in a timely and competent manner.

Also, conscientious objectors often request exemptions from broad policy and legal requirements. Thus, these claims must be considered carefully, and an important factor in that analysis is the cost to the state of making exceptions from rules that may represent important health care objectives.

³⁵ Holly Fernandez Lynch, *Conscientious Refusals by Physicians* in The Penn Center Guide to Bioethics (Springer Publishing Co. March 2009) 159, 161 (citation omitted)(hereinafter “*Conscientious Refusals*”).

³⁶ Kent Greenawalt, *Refusals of Conscience: What Are They and When Should They Be Accommodated?* 9 Ave Maria L. Rev. 47, 54 (2010)(hereinafter “*Refusals of Conscience*”).

³⁷ Julie Cantor and Ken Baum, *The Limits of Conscientious Objection – May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?* 351 New England Journal of Medicine, 2008, 2009 (2004)(hereinafter “*The Limits of Conscientious Objection*”).

Understanding the debate over conscientious objection in the health care field requires attention to these traditional liberties and responsibilities.

Another key to understanding the debate is appreciating its relationship to the continuing battle over abortion. During our day-long interdisciplinary convening to discuss conscience in the context of health care, theologian and bioethicist Gilbert Meilaender said: “[W]e should remember that we would not be having this conversation here today were it not for the issue of abortion and the way that has deeply divided our country.”³⁸ To be sure, Meilaender noted, there are other claims of conscience in the health care field, but abortion is “the fundamental issue.” For Meilaender, the deep divisions over abortion are “a powerful reason not to require any individual or institution to do it.”³⁹

Sharp differences over abortion animate the conscience debate in other ways. Professor Alta Charo explains:

Some health care providers ... distinguish between medical care and nonmedical care that uses medical services. In this way, they justify their willingness to bind the wounds of the criminal before sending him back to the street or to set the bones of a battering husband that were broken when he struck his wife. Birth control, abortion, and in vitro fertilization, they say, are lifestyle choices, not treatments for disease.⁴⁰

Others vehemently reject this characterization, asserting that reproductive services are essential to women’s health, dignity, and equality. Reducing abortion and contraception to “notions of convenience, elective services you can just find if you want [them],” is deeply troubling, they say.⁴¹

The conscience question is not whether particular health services are legitimate, but whether an individual or institutional provider has the liberty to abstain from providing them due to religious or moral objections. Nonetheless, it often proves difficult to divorce these matters.

To understand current debate over conscientious objection in the health care field, one must also appreciate the ways in which the new federal health care reform law is changing this landscape. An example is the recent debate over the HHS ruling requiring most new health insurance plans to cover contraceptives and sterilization procedures without co-pays or deductibles. Does the accommodation announced by

³⁸ In conversation with authors at The Brookings Institution, June 6, 2011.

³⁹ *Id.*

⁴⁰ R. Alta Charo, *The Celestial Fire of Conscience – Refusing to Deliver Medical Care*, 352 N. Engl. J. Med. 2471 (June 16, 2005).

⁴¹ Tracy Weitz in conversation with the authors at The Brookings Institution, June 6, 2011.

the Obama Administration on February 10, 2012 sufficiently protect the rights and interests of all the stakeholders? A number of states have already addressed these matters, but regulations issued pursuant to the Patient Protection and Affordable Health Care Act of 2010 are the first federal rules to tackle these subjects.

In the sections of the paper that follow, we describe aspects of current law and policy on conscience in the health care context and certain contours of the debate about what law and policy should be. The final section of the paper offers some suggestions for policymakers as they address issues in this field.

Current law on conscience in the health care context

In the health care context, conscience laws protect medical providers and institutions that refuse to provide certain services due to their religious or moral objections to such services. The U.S. Constitution and many state constitutions generally do not mandate these kinds of protections for conscientious objectors,⁴² but they often permit the legislative and executive branches of government to extend them. The federal government and most state governments have done so in a variety of ways.

Federal law and regulation

Several major federal laws protect conscientious objections in the health care field. Congress passed a series of these measures in the 1970s. With these provisions, Congress made it clear that individuals and institutions must be excused from providing services that are morally or religiously objectionable to them in many cases.

Congress passed a law weeks after the U.S. Supreme Court's 1973 decisions in *Roe v. Wade* and *Doe v. Bolton* striking down certain state laws restricting abortion.⁴³ This law is known as the Church Amendment for its leading proponent, Idaho Senator Frank Church. In the wake of these Supreme Court decisions, there were

⁴² So long as laws and other governmental action are generally applicable and neutral toward religion, they do not offend the free exercise clauses of these constitutions. See *Employment Division v. Smith*, 494 U.S. 872 (1990); Douglas Laycock, *The Religious Exemption Debate*, 11 Rutgers J. Law & Religion 139 (2009). See also *infra* 21-22. Also, claims of conscience divorced from religious concerns fall outside the ambit of the First Amendment and similar state constitutional provisions. However, some state courts have interpreted the free exercise clauses of their state constitutions to provide much more protection for religious exercise. See Douglas Laycock, *The Religious Exemption Debate*, 11 Rutgers J. Law & Religion 139, 142 & n.16 (2009). Also, a federal statute and some state statutes provide additional protection for free exercise rights. See *infra* 21-22.

⁴³ Thaddeus Mason Pope, *Legal Briefing: Conscience Clauses and Conscientious Refusals*, 21 The Journal of Clinical Ethics 163 (2010); *Roe v. Wade*, 410 U.S. 113 (1973). In *Doe v. Bolton*, the Court said statutory provisions excusing individuals and hospitals from performing abortions were "appropriate protection." *Doe v. Bolton*, 410 U.S. 179, 198 (1973).

efforts to pressure some physicians and health care institutions to perform abortions or sterilizations despite their conscientious objections. These efforts were often premised on the fact that the health care institution or individual received federal funds.⁴⁴

In response, Congress said the receipt of certain federal funds could not serve as the basis for requirements that objecting individuals or institutions perform abortions or sterilizations or make facilities or personnel available to perform these procedures.⁴⁵ It also banned employment discrimination on these grounds. The Church Amendment prohibits employers from penalizing a medical professional due to his or her refusal to perform a lawful sterilization or abortion or willingness to perform such procedures.⁴⁶ Similarly, the Amendment bars entities from discriminating on these bases regarding “the extension of staff or other privileges to any physician or other health care personnel.”⁴⁷

Through passage of the National Research Act in 1974,⁴⁸ Congress added new provisions to the Church Amendment,⁴⁹ ones stating that individuals cannot be required to perform or assist in performing “any part of a health service program or research activity” funded by the Department of Health and Human Services if doing so would be objectionable to the individual for religious or moral reasons.⁵⁰ Likewise, an entity receiving federal funding for biomedical or behavioral research may not discriminate in employment or in the extension of staff privileges based on a person’s “performance of any lawful health service or research activity” or refusal to do so for reasons of conscience.⁵¹

Congress added another provision to the Church Amendment in 1979. This provision prohibits entities receiving certain federal funds from discriminating in admissions for medical training or study based on a person’s reluctance or willingness “to counsel, suggest, recommend, assist, or in any way participate” in

⁴⁴ See, e.g., *Taylor v. St. Vincent’s Hospital*, 369 F. Supp. 948 (D. Mont. 1973).

⁴⁵ 42 U.S.C. Section 300a-7(b)(1) and (2).

⁴⁶ *Id.* at Section 300a-7(c)(1)(A).

⁴⁷ *Id.* at Section 300a-7(c)(1)(B).

⁴⁸ Public Law 93-348, 88 Stat. 342 (1974). A firestorm of public criticism of the Tuskegee syphilis study led to the passage of this legislation. In this U.S. Public Health Service study, hundreds of low-income African American men who were suffering from syphilis were monitored for decades, but these men were neither informed about the specific nature of their disease nor treated for it. See History of Research Ethics, Office of Graduate Studies, University of Nevada Las Vegas at <http://research.unlv.edu/ORI-HSR/history-ethics.htm>; Center for Disease Control and Prevention, *U.S. Public Health Service Act Syphilis Study at Tuskegee*, at <http://www.cdc.gov/tuskegee/after.htm>.

⁴⁹ 42 U.S.C. at Section 300a-7(d).

⁵⁰ *Id.* at Section 300a-7(d).

⁵¹ *Id.* at Section 300a-7c(2).

abortions or sterilizations due to the individual's moral convictions or religious beliefs.⁵²

Decades later Congress drafted other laws extending these principles. When accreditation standards threatened to require hospitals to provide abortions or abortion training and referrals in the 1990s, Congress prohibited federally funded governmental bodies from penalizing any individual or entity for refusing to receive or provide abortion training and referrals or perform abortions.⁵³ And in 2004 and every subsequent year, Congress has said federal funds cannot be used to discriminate against any individual or entity because it refuses to provide, pay for, provide coverage, or make referrals for abortions.⁵⁴

None of these statutes were supported by regulations until 2008. In the final days of the George W. Bush administration, the Department of Health and Human Services issued such a regulation.⁵⁵ The Department said it was concerned about growing intolerance toward conscience protections in the health care field and “[a] trend that isolates and excludes some among various religious, cultural, and/or ethnic groups from participating in the delivery of health care.”⁵⁶

The regulation was not intended to expand the protections of the federal conscience statutes but rather to enforce them, the Department said. At the same time, HHS emphasized that the rule was “to be interpreted and implemented broadly to effectuate [its] protections.”⁵⁷ The rule provided definitions for various terms in these statutes. For example, it said “assist in the performance” meant “to participate in any activity with a reasonable connection to a procedure, health service or health service program, or research activity. . . .”⁵⁸ It also required certain recipients of health care funds to certify compliance with these federal statutes in writing. Finally, the rule designated the HHS Office of Civil Rights as the entity to receive complaints concerning violations of these statutes.

This regulation was deeply controversial. Opponents of the regulation filed lawsuits against it, while advocates of the rule enthusiastically defended it.

⁵² *Id.* at Section 300a-7(e).

⁵³ *Id.* Section 238n (2011).

⁵⁴ Annual rider to Health and Human Services/Labor Appropriations Bill, recently re-enacted as part of the Omnibus Appropriations Act of 2009, Pub. L. No. 111-8, Div. F, Section 508(d)(1) (March 11, 2009). This paper does not provide an exhaustive description of federal conscience clause laws. For a fuller account of such laws, see, e.g., Thaddeus Mason Pope, *Legal Briefing: Conscience Clauses and Conscientious Refusals*, 21 *The Journal of Clinical Ethics* 163 (2010).

⁵⁵ 73 Fed. Reg. 78071 (December 19, 2008); 45 CFR Part 88 (2008).

⁵⁶ *Id.* at 78073.

⁵⁷ *Id.* at 78097.

⁵⁸ *Id.*

Shortly after President Barack Obama took office in January 2009, the Department of Health and Human Services proposed rescinding this regulation in its entirety, and it did rescind most of the regulation on February 23, 2011.⁵⁹ HHS said the rule created more confusion than clarity; improperly expanded the conscience statutes, mostly through the creation of overly broad definitions for statutory terms; and threatened access to reproductive services like contraception. It rescinded the definitions and the certification requirement, but HHS retained the portion of the rule charging the Department's Office of Civil Rights with educating the health care field about these federal statutes and enforcing them. Even as it rescinded most of the 2008 rule, HHS stressed that the federal statutory conscience protection laws would remain unchanged.⁶⁰ As discussed previously, the implementation of federal health care reform law has led to the issuance of another regulation implicating conscience issues, one mandating coverage for contraception and sterilization services in most new group health insurance plans.⁶¹

State law

Most states have enacted laws protecting conscientious objectors in the health care field. According to a 2011 report by the Guttmacher Institute:

- 46 states have laws allowing some health care providers to refuse to perform abortion-related services, and 44 states permit health care institutions to refuse to provide abortions.⁶²
- 18 states honor the objections of some health care providers to providing sterilization services, and 16 states allow health care institutions to refuse to do so.
- 14 states allow some health care providers to refuse to provide contraceptive services. Six states explicitly allow pharmacists to refuse to dispense contraceptives for moral or religious reasons.⁶³

A growing number of states also have statutes on their books known as “contraceptive equity laws.” These laws require employers to offer prescriptive contraceptives to their employees as part of their health care plans, if those plans cover other prescriptive drugs and devices. According to a November 2010 report

⁵⁹ Office of the Secretary of Health and Human Services, Final Rule, *Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws* (February 23, 2011) at <http://www.gpo.gov/fdsys/pkg/FR-2011-02-23/pdf/2011-3993.pdf>

⁶⁰ *Id.*

⁶¹ *See supra* 1-5.

⁶² Guttmacher Institute, *State Policies in Brief: Refusing to Provide Health Services* (February 1, 2012) at http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf

⁶³ *Id.* *See also* Jody Feder, *Federal and State Laws Regarding Pharmacists Who Refuse to Dispense Contraceptives* at CRS-2 (Congressional Research Services, October 7, 2005).

by the National Women's Law Center, twenty-six states have such laws.⁶⁴ Some of these laws contain exemptions for certain employers having religious objections to the use of contraception, though these exemptions vary in terms of the breadth of religious entities they cover.⁶⁵

Federal and state law on religious nondiscrimination and accommodation

All of the federal and state laws that make room for conscientious objections in the context of health care recognize religious objections. But faith-based objections are given added protection through more general laws aimed at prohibiting religious discrimination and providing religious accommodation.

For example, the Religious Freedom Restoration Act (RFRA) of 1993 requires the federal government to justify any substantial burdens it places on religious exercise with a compelling government interest and to demonstrate that its promotion of that interest places only the most minimal burden possible on religious exercise.⁶⁶ It protects the religious exercise of both individuals and institutions from governmental interference. Some states have statutes like the federal RFRA and others interpret their constitutions to provide similar protection.⁶⁷

Individuals with religious objections to providing certain health care services also sometimes invoke workplace nondiscrimination statutes such as Title VII of the 1964 Civil Rights Act.⁶⁸ Title VII requires employers with fifteen or more employees to provide reasonable accommodation for an employee's sincere religious beliefs, practices, and observances, if doing so would not create an undue hardship for the employer.⁶⁹ The Supreme Court has said the term "undue

⁶⁴ National Women's Law Center, *Contraceptive Equity Laws in Your State: You're your Rights-Use Your Rights, A Consumer Guide* (November 30, 2010) at <http://www.nwlc.org/resource/contraceptive-equity-laws-your-state-know-your-rights-use-your-rights-consumer-guide-0>. The United States Conference for Catholic Bishops has noted that two additional states, Michigan and Washington, have administrative rules or regulations to similar effect. See Comments of the United States Conference of Catholic Bishops on Interim Final Rules on Preventive Services File Code CMS-9992-IFC2 (August 21, 2011) at <http://www.usccb.org/about/general-counsel/rulemaking/upload/comments-to-hhs-on-preventive-services-2011-08.pdf>

⁶⁵ See *supra* 1-5 for a discussion of a related federal regulation.

⁶⁶ 42 U.S.C. Section 20000bb-4 (2011). In 1997, the U.S. Supreme Court invalidated the application of RFRA to states and localities. See *City of Boerne v. Flores*, 521 U.S. 507 (1997). RFRA continues to apply to the actions of the federal government. See *Gonzales v. O Centro Espirita*, 546 U.S. 418 (2006).

⁶⁷ See Douglas Laycock, *The Religious Exemption Debate*, 11 Rutgers J. Law & Religion 139, 142 & nn.16 & 17 (2009).

⁶⁸ 42 U.S.C. Section 2000e (2011).

⁶⁹ 42 U.S.C. Section 2000e(j) states: "The term 'religion' includes all aspects of religious observance and practice, as well as belief, unless an employer demonstrates that he is unable to reasonably

hardship” means anything more than a *de minimis* cost or burden.⁷⁰ Thus, if an employer can demonstrate that accommodating the employee would create more than a minimal burden or cost, the employer need not make the adjustment.⁷¹ Title VII accommodation protections have often been invoked by conscientious objectors in the health care field, sometimes successfully.⁷² States and many localities have similar prohibitions on work place discrimination.⁷³

Can governmental accommodation of religious practices sometimes violate the Constitution? Yes. The First Amendment’s Establishment Clause prohibits the government from singling out religious practices and institutions for accommodation in ways that would markedly burden nonbeneficiaries, for example.⁷⁴ In a 2005 case, a unanimous Supreme Court said: “[C]ourts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries.”⁷⁵ Many conscience laws and policies in the health care context, however, encompass objections rooted in ethical as well as religious convictions, and some seek to balance the burdens of the conscience objector against the burdens borne by the person needing health care services. Laws and policies singling out religious institutions and practices for special exemptions and providing absolute protection for them may be more vulnerable to constitutional attack.⁷⁶

What law and policy should be: Areas of agreement and disagreement

In addition to describing what current law *is* on these issues, this paper also seeks to map some of the contours of the debate about what the law and policy *should be*. This debate focuses on a number of key questions, including:

- Who should be permitted to refuse to provide, pay for, or assist in the provision of certain health care services?

accommodate to an employee's or prospective employee's religious observance or practice without undue hardship on the conduct of the employer's business.”

⁷⁰ *Trans World Airlines v. Hardison*, 432 U.S. 63 (1977).

⁷¹ *Id.*

⁷² See, e.g., Robin Fretwell Wilson, *Insubstantial Burdens: The Case for Government Employee Exemptions to Same-Sex Marriage Laws*, 5 Nw. J.L. & Soc. Pol’y 318 (2010).

⁷³ Ira C. Lupa and Robert W. Tuttle, *Government Partnerships with Faith-Based Service Providers: State of the Law 2002* (Roundtable on Religion and Social Welfare Policy, December 2002) at http://www.rockinst.org/pdf/faith-based_social_services/2002-12-government_partnerships_with_faith-based_service_providers_state_of_the_law.pdf

⁷⁴ See *Texas Monthly v. Bullock*, 489 U.S. 1, 15 (1989).

⁷⁵ *Cutter v. Wilkinson*, 544 U.S. 709, 721 (2005).

⁷⁶ *Thornton v. Caldor*, 472 U.S. 703 (1985).

- Which institutions, if any, should be permitted to refuse to provide, pay for, or assist in the provision of certain health care services?
- What are appropriate grounds for conscientious refusals?
- What should conscientious objectors be able to refuse to do? Should providers be able to raise an objection regarding any health care service, or just some of them?
- What conditions must be present for conscientious objections to be honored?
- What sort of rules should govern disclosures of conscientious objections, notifications regarding alternative providers, and referrals to other providers?

We address each of these questions in turn.

Who should be permitted to refuse to provide or assist in the provision of certain lawful health care services?

Should nurses as well as doctors be able to raise conscientious objections in the health care field? What about hospital orderlies and pharmacists?

Some would draw a line between doctors and everyone else. Physicians should be permitted to decline to perform at least some services they find objectionable, they say, but nurses and others should be treated differently. In their view, nurses merely assist while doctors perform the procedures. Others believe, however, that nurses—and for some, other health care workers, too—should also be excused from performing or assisting in procedures they find morally objectionable.

Rather than simply considering a job title, another approach is to consider the provider's personal contact with patients. Columbia University Law School Professor Kent Greenawalt has suggested the line might be drawn at those having "significant personal contact with patients." Greenawalt explains: "So long as there is no significant personal contact with the patients, I do not think everyone remotely connected to patients, including those who type their forms, make their beds, dish out their meals, and clean their rooms, should have a right of conscience to refuse based on the procedure the patient undergoes."⁷⁷ Applying this standard, Greenawalt suggests it would be possible to distinguish between nurses and pharmacists, for example, because a pharmacist's contact with those seeking

⁷⁷ Greenawalt, *Refusals of Conscience*, 9 Ave Maria L. Rev. at 27.

contraceptives is much more remote than a nurse's contact with a patient seeking an abortion.⁷⁸

A related approach focuses on the health care worker's tie to the objectionable procedure. A narrow view would only honor objections to direct participation in the procedure itself. A much broader view would also excuse an objector from participating in any other care for the patient, such as pre- or post-operative care.⁷⁹

Regardless of which of these standards is applied, most agree that if an individual objects to a large portion of the duties required by a particular line of work, the individual's conscience claim is weak. A federal court put it this way in the context of a Title VII religious accommodation claim: An employer does not have to accommodate an employee when the employee's objections would render him "unable to perform a substantial proportion of the duties of a particular position."⁸⁰ While there is widespread agreement on this general principle, there are frequent disagreements about exactly what constitutes a "substantial proportion" of a health care worker's duties.

Which institutions, if any, should be permitted to refuse to provide, pay for, or assist in the provision of certain lawful health care services?

Should some institutions be allowed to refuse to provide certain health care services due to religious or moral objections to those procedures by their sponsoring communities? Groups and institutions are often formed around shared notions of conscience and the rights of freedom of assembly and association apply to these groups. If the group is religious, the rights of free exercise and religious autonomy apply as well. Thus, some argue that refusing to recognize the ability of certain institutions to object to the provision of particular services would interfere with the liberties of these institutions and lead to an overly privatized notion of conscience, one cut off from the collective thought and traditions that often distinguish groups given to ethical, moral or religious reflection. Professor Jean Bethke Elshtain highlights another dimension of this argument: "If you begin to eviscerate freedom of institutions, you in effect cut off conscience formation at its knees; that is, you

⁷⁸ *Id.* at 20.

⁷⁹ See, e.g., Seth Augenstein, *Twelve nurses accuse UMDNJ of forcing them to assist in abortion cases despite religious and moral objections*, New Jersey Star Ledger (November 14, 2011) at http://blog.nj.com/ledgerupdates_impact/print.html?entry=/2011/11/12_nurses_accuse_umdnj_of_forc.html (attorney for the nurses argues that they "would be assisting with the abortion even if they were taking down name, holding a patient's hand during the procedure, or walking them to the door"). See also Rob Stein, *New Jersey Nurses Charge Discrimination Over Hospital Abortion Policy*, The Washington Post (November 27, 2011) at http://www.washingtonpost.com/national/health-science/new-jersey-nurses-charge-religious-discrimination-over-hospital-abortion-policy/2011/11/15/gIQAYdgm2N_story.html See also *supra* 1 for further discussion of this New Jersey case and 19-20 for broad definitions of statutory terms from now-defunct Bush conscience regulation.

⁸⁰ *Haring v. Blumenthal*, 471 F. Supp. 1172, 1184 (1979).

need institutions to generate conscience to help form people who have consciences.”⁸¹

Others insist there is no justification for honoring conscientious objections raised by institutions.⁸² Institutions do not have a conscience, they note. They also make a pragmatic argument: institutional objections often pose greater threats for access to health care services than individuals’ conscientious objections. An institution may staff around the objections of individual health care workers. But when an institution objects to the provision of certain health care services, even willing health care workers within that institution may be prevented from providing such care.

Some have suggested that only religious entities should enjoy an institutional right of refusal. These bodies have special rights to be free from state interference, including First Amendment rights to religious autonomy and free exercise.⁸³ From America’s founding, they argue, it has been recognized that religious communities require the freedom to define themselves and practice their faith as they see fit rather than as government sees fit. This freedom encompasses the liberty to establish and maintain communities that operate according to a set of religious beliefs and practices.

Others say this kind of special treatment for religion is unconstitutional and wrongheaded. “To single out one of the ways that persons come to understand what is important in life, and grant those who choose that way a license to disregard legal norms that the rest of us are obliged to obey is to defeat rather than fulfill our commitment to toleration,” legal scholars Christopher Eisgruber and Lawrence Sager argue.⁸⁴ Especially because religion defies easy categorization, it is folly at best to try to define religion in law and policy and treat it differently, they claim.⁸⁵ Further, questions are sometimes raised about whether religiously

⁸¹ In conversation with the authors at The Brookings Institution, June 6, 2011.(hereinafter quotes from June 6, 2011 convening cited as “Brookings discussion”).

⁸² ACLU Reproductive Freedom Project, *Religious Refusals and Reproductive Rights Accessing Birth Control at the Pharmacy* at 2.

⁸³ Greenawalt, *Refusals of Conscience*, 9 Ave Maria L. Rev. at 12. Professor Kent Greenawalt argues that, “[w]hen nonreligious organizations are created for particular purposes, such as medical care, there is much less reason to permit them to decline services that are generally required.” Kent Greenawalt, *The Significance of Conscience*, 47 San Diego L. Rev. 901, 916 (2010).

⁸⁴ Christopher L. Eisgruber & Lawrence G. Sager, *The Vulnerability of Conscience: The Constitutional Basis for Protecting Religious Conduct*, 61 Chi. L. Rev. 1245, 1315 (1994). For a critique of the proposals of Professors Eisgruber and Sager, see Thomas C. Berg, *Can Religious Liberty Be Protected as Equality?* 85 Tex. L. Rev. 1185 (2007).

⁸⁵ See, e.g., Winnifred Fallers Sullivan, *The Impossibility of Religious Freedom* (Princeton, 2005).

affiliated health care institutions continue to serve a distinctive purpose today, particularly when these institutions are heavily dependent on government funds.⁸⁶

Where religious entities *are* exempted from certain health care mandates, there are fierce battles over the scope of those exemptions. Sometimes the terms “religious organizations” or “religious employers” are defined broadly to include not only houses of worship but also faith-based nonprofits and religiously affiliated educational institutions at all levels. This usually triggers an outcry from certain health care advocates who say these exemptions allow too many people working within or associated with religious institutions to be denied the benefits of the state’s health care mandates. A narrow exemption for religious entities also draws serious opposition, albeit from different quarters.⁸⁷

What are appropriate grounds for conscientious refusals?

The federal and state statutes and regulations regarding conscience in the health care context protect the rights of individuals to raise moral or religious objections. This reflects the consensus view that it would be unfair to force individuals to perform abortions, for example, simply because their objections are rooted in ethics rather than religion. Given the serious burdens it could place on similarly situated nonreligious health care providers, it could also raise questions about whether the state is favoring religion over nonreligion, something the First Amendment forbids.⁸⁸

Must conscientious objections have a “reasonable factual basis”? Some would limit objections in the health care field in this way. For example, the American Congress of Gynecologists and Obstetricians (ACOG) has said: Because “a large body of published evidence” indicates that emergency contraception prevents fertilization rather than implantation, “provider refusals to dispense emergency contraception based on unsupported beliefs about its primary mechanism of action should not be justified.”⁸⁹ At least when claims of faith are involved, however, this kind of

⁸⁶ For example, Catholic theologian Daniel C. Maguire argues there was a need for Catholic hospitals in the United States years ago when no other institution was providing health care for the poor and non-governmental funds supported the work of these hospitals. Now other institutions are providing such care, Maguire says, and Catholic hospitals are totally dependent on government funds. Thus, Maguire suggests Catholic and other religiously affiliated hospitals “should be sunsetted.” Brookings discussion.

⁸⁷ See, e.g., *Catholic Charities v. Superior Court*, 32 Cal. 4th 527 (2004). See also *supra* 1-6.

⁸⁸ Recognizing only the conscientious objections of religious individuals would burden more non-beneficiaries than recognizing only the objections of religious institutions. Few non-religious health care institutions assert ethical or moral objections to providing services like abortion and sterilization.

⁸⁹ Committee on Ethics of the American College of Obstetricians and Gynecologists, Committee Opinion: *The Limits of Conscientious Refusal in Reproductive Medicine* (November 2007) at http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Ethics/The

requirement would seem to be in some tension with Supreme Court mandates. The Court has said: “[R]eligious beliefs need not be acceptable, logical, consistent, or comprehensible to others in order to merit First Amendment protection.”⁹⁰

What about objections appearing to stem from a patient’s status rather than the nature of a particular service? Some health care providers have said they will provide infertility services to married heterosexual couples, for example, but they will not provide such services to single women or same-sex married couples due to a religious or moral belief that children should only be reared by heterosexual married couples. Are these appropriate grounds for conscientious refusals?

Many say “no.” Indeed, experts like Holly Fernandez Lynch say this is an easy call—“refusals based on objections to the patient who is requesting the service, rather than to the service itself, should be deemed unacceptable.”⁹¹ In 2008, the Supreme Court of California came to the same conclusion.⁹² When a lesbian sought fertility treatment at a clinic and was refused, she sued the clinic. Some of the physicians associated with the clinic said their religious beliefs precluded them from performing the requested procedure for the patient. The patient sued under a state law barring discrimination on the basis of sexual orientation by businesses offering services to the public.⁹³ The court held that the medical group was such a business, and it ruled in favor of the patient, finding that the nondiscrimination law advanced “California’s compelling interest in ensuring full and equal access to medical treatment irrespective of sexual orientation, and there [was] no less restrictive means for the state to achieve that goal.”⁹⁴

Others believe this status-service distinction is not so clear. Notre Dame Professor Cathleen Kaveny notes that there are a number of occasions where it is difficult to judge the morality of a service apart from the person to whom the service is given. A physician might tell a preteen, for example, that she is too young for sexual

[Limits of Conscientious Refusal in Reproductive Medicine](#) (hereinafter “*The Limits of Conscientious Refusals*”). See also Lynch, *Conscientious Refusals* at 165.

⁹⁰ Thomas v. Review Bd., 450 U.S. 707, 714 (1981).

⁹¹ Lynch, *Conscientious Refusals* at 165. See also ACOG, *The Limits of Conscientious Refusals* at 4.

⁹² North Coast Women’s Care Medical Group v. Superior Court, 44 Cal. 4th 1145 (Sup. Ct. Calif. 2008).

⁹³ The state statute involved in this case prohibits discrimination by businesses offering the public “accommodations, advantages, facilities, privileges, or services.” *Id.* at 1153. There is no universal definition of a “public accommodation,” but it usually is defined as a business or building where services are offered to the general public. See, e.g., Boy Scouts of America v. Dale, 530 U.S. 640 (2000); Romer v. Evans, 517 U.S. 620, 628 (1996). A number of state statutes explicitly name institutions like hospitals, clinics, and pharmacies as public accommodations. See, e.g., Colo. Rev. Stat. Ann. Section 24-34-601 (2011); Wis. Stat. Sec. 106.52 (2011); Mass. Ann Laws ch. 272 Sec. 92A (2011). Whether this term accurately describes small medical practice groups is a matter of debate.

⁹⁴ North Coast Women’s Care Medical Group v. Superior Court, 44 Cal. 4th at 1158.

activity and thus also too young for birth control.⁹⁵ Legal scholar Robin Fretwell Wilson agrees that the status-service distinction is not always bright, but she counsels that policymakers often see things this way, particularly when conscientious objections are connected to sexual orientation or gender.⁹⁶

What should objectors be able to refuse to do? Should providers be able to raise an objection regarding any health care service, or just some of them?

The issue of conscientious objection is most commonly tied to abortion, but health care workers have also raised religious or moral objections to participating in sterilizations, euthanasia, blood transfusions, assisted suicide, reproductive technology, embryonic stem-cell research, and other procedures. While some argue that all moral or religious objections in the health care field should be given the same high degree of protection, others fear this would bring the health care system to a screeching halt.

At the same time, it is not necessarily clear that one can draw legitimate distinctions among various objections, at least if honoring subjective notions of conscience is the touchstone for decision making. For a Jehovah's Witness, for example, participating in a blood transfusion may be as disturbing as it would be for a Catholic to participate in an abortion.⁹⁷

Some argue instead that one class of conscience claims is objectively different from all others—claims involving matters of life and death. George Washington University Law School Professors Ira Lupu and Robert Tuttle explain the rationale underlying this perspective:

The widespread acceptance of a right to conscientious objection rests on a shared recognition that abortion has a moral character that is categorically distinct from other practices, medical or otherwise. Exemptions from mandatory provision of abortion services, like exemptions from conscription in times of war, focus specifically on those who might be forced to terminate human life. In other words, the exemption reflects the specific moral character of the act, rather than a more general deference to the subjective demands of conscience. Thus, proponents of exemptions have been much less successful in enacting broader measures that would exempt

⁹⁵ Brookings discussion.

⁹⁶ *Id.*

⁹⁷ This could implicate the constitutional prohibition against governmental favoritism for one faith over another. *See, e.g.,* Epperson v. Arkansas, 393 U.S. 97, 104 (1968) (“The First Amendment mandates governmental neutrality between religion and religion, and between religion and nonreligion.”)

healthcare professionals and facilities from any obligation to provide services they might deem objectionable.⁹⁸

While there is no consensus on the standard that should be applied to conscientious objections, there is widespread agreement that the right to refuse to participate in the delivery of a particular service does not include the right to attempt to block a patient from accessing that service. If a pharmacist tears up a prescription for the morning-after pill, for example, that moves far beyond refraining from participating in the delivery of a service and qualifies as an impermissible effort to block access to that service. “[A]lthough health professionals may have a right to object,” scholars Julie Cantor and Ken Baum have said, “they should not have a right to obstruct.”⁹⁹

What conditions must be present for conscientious objections to be honored?

Some argue individual and institutional health care providers should always be able to decline to provide objectionable medical services. This is particularly true when the service involved is abortion, sterilization, and assisted suicide.¹⁰⁰

Most, however, advocate striking some kind of balance between the competing interests of conscience and access to health care. The case presenting the strongest claim for patient access is when a patient is experiencing a medical emergency and another health care provider is not immediately available to serve the patient.¹⁰¹ In such a case, there is wide consensus that the physician or institution has a professional and ethical, if not a legal, duty to care for the patient.

An Arizona Catholic-affiliated hospital came to such a conclusion when it was presented with a case in which a pregnant woman had pulmonary hypertension. Her life was in danger, and her fetus was dying, the hospital said, so it sanctioned an abortion. When the presiding bishop learned about the case, however, he rebuked the hospital and stripped it of its Catholic affiliation.¹⁰² The performance

⁹⁸ Ira C. Lupu and Robert W. Tuttle, *Same-Sex Family Equality and Religious Freedom*, 5 N.W. J.L. & Soc. Pol’y 274 (2010).

⁹⁹ Cantor and Baum, *The Limits of Conscientious Exemption* at 2012.

¹⁰⁰ According to legal scholar Robin Fretwell Wilson, twenty states follow federal law by providing an absolute exemption for conscientious objectors who oppose participating in abortions and sterilizations. See Robin Fretwell Wilson, “Matters of Conscience: Lessons for Same-Sex Marriage from the Healthcare Context,” *Same Sex Marriage and Religious Liberty: Emerging Conflicts* (Rowman & Littlefield 2008): 77-102. The same is often true of statutes dealing with objections to participating in assisted suicide. See e.g., Oregon’s Death with Dignity Act, ORS Sec. 127.885 Section 4.01(4) (2009) (“No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner.”)

¹⁰¹ See *supra*

¹⁰² National Catholic Reporter, *Phoenix bishop removes hospital’s Catholic status* (December 21, 2010) at <http://ncronline.org/news/phoenix-bishop-removes-hospitals-catholic-status>.

of the procedure violated Catholic doctrine, he said.¹⁰³ The bishop maintained that “the baby was healthy and there were no problems with the pregnancy; rather, the mother had a disease that needed to be treated.”¹⁰⁴ In related communications, the diocese said “the mother’s life cannot be preferred over the child’s,” even when the baby cannot survive outside the womb and the mother may die.¹⁰⁵ Especially given the fact that Catholic-affiliated hospitals are the largest group of nonprofit hospitals in the United States and account for 17 percent of all hospital admissions annually,¹⁰⁶ this case has drawn national attention.¹⁰⁷

If a community only has effective access to one hospital or one doctor, many also agree that these providers must offer care to the patient. Defenders of a broad understanding of conscience rights warn, however, that forcing the “last doctor” or “last hospital” in town to offer services to which they object may cause them to leave their communities. If this happens, these communities would be deprived of their only sources of many different kinds of health care services. This is a powerful reason, they say, to honor conscientious objections.

Sociologist Tracy Weitz articulates a passionate retort to this point. “The idea that we would accept a lesser standard for a group of people because there is nobody else who is going to do it just hits my moral core,” Weitz says. If the lone hospital, for example, will not offer the service, “then the state has an obligation to backfill

¹⁰³ Catholic doctrine states: “Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.” See United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Fifth Edition (November 17, 2009).

<http://www.ncbcenter.org/document.doc?id=147>

¹⁰⁴ Statement of Bishop Thomas J. Olmsted (December 21, 2010) at

<http://www.arizonacatholic.org/wp-content/uploads/2010/12/DIOCESE-OF-PHOENIX-STATEMENT-122110.pdf>

¹⁰⁵ See Diocese of Phoenix, *Questions and Answers Re: The Situation at St. Joseph’s* (May 18, 2010) at <http://www.catholicsun.org/2010/phxdio-stjoes/Q-AND-A-ST-JOSEPH-HOSPITAL-FINAL.pdf>

¹⁰⁶ Guttmacher Institute, *Advocates Work to Preserve Reproductive Health Care Access When Hospitals Merge* (April 2000) at <http://www.guttmacher.org/pubs/tgr/03/2/gr030203.pdf>.

¹⁰⁷ In an effort to address aspects of this problem, some Catholic hospitals have allowed tiny, separately incorporated secular hospitals to operate within them and to provide services like sterilizations that Catholic hospitals refuse to provide. See Rachel Benson Gold, *Advocates Work to Preserve Reproductive Health Care Access When Hospitals Merge*, The Guttmacher Report on Public Policy (April 2000) at <http://www.guttmacher.org/pubs/tgr/03/2/gr030203.pdf>. Apparently, however, the Catholic Church has found these arrangements unacceptable in recent years, and they are being discontinued. *Id.*; also Brookings discussion. Although physicians and nurses on the staff of some Catholic hospitals are willing and able to provide sterilizations, they generally are not permitted to do so within those institutions. (While measures like the Church Amendments protect the doctor who provides abortions from being discriminated against by an institution that objects to them, they do not provide such a doctor with the right to perform abortions on the premises of an objecting institution.) This means, for example, that patients who are served by Catholic hospitals and require Caesarean sections must undergo a second operation at another facility if they wish to have sterilization procedures following their Caesareans.

those services in a way that allows a sole-source hospital to survive but [does not] accept a lesser standard of available services.”¹⁰⁸

To avoid dilemmas like these, bioethicist Holly Fernandez Lynch has proposed that the focus shift from individual medical professionals to the profession as a whole because it is the entity that holds “a collective monopoly” over provision of medical services. Institutions like state licensing boards should monitor supply and demand and provide incentives for willing doctors to practice in areas where refusals threaten patient access, Lynch says. If professional entities perform these functions, Lynch argues, it can help guarantee that “monopoly power of the profession never (or at least rarely) trickles down to individual physicians.”¹⁰⁹

What if claims about lack of access to health care services are really complaints about mere inconvenience for the patient? Referencing a lawsuit filed in 2006 over the right of pharmacists in the state of Washington to refuse to provide emergency contraception, Luke Goodrich of The Becket Fund for Religious Liberty says:

[D]espite years of factfinding during rulemaking and discovery, and despite a concerted canvassing effort by Planned Parenthood, it was undisputed in the factual record of the litigation that pro-choice groups were unable to find a single example of a patient in Washington who was denied the morning-after pill for reasons of conscience and was unable to timely obtain the drug elsewhere.

This result is not surprising given how widely available the morning-after pill is. It is available not only at pharmacies, but also at physicians’ offices, government health centers, hospital emergency rooms, and via a toll-free hotline. It is available at Planned Parenthood’s network of nearly one thousand centers across the country, many of which are in rural and impoverished areas. And it is available from online drugstores with overnight home delivery. The fact that a small fraction of pharmacies or pharmacists may decline to dispense the drug for reasons of conscience does not mean the drug is inaccessible.¹¹⁰

Some advocates of women’s health care concede that it is relatively easy for a patient to access emergency contraception today, but they also argue that it is much more difficult to access emergency abortion care.¹¹¹ Thus, protecting the rights of

¹⁰⁸ Brookings discussion.

¹⁰⁹ Lynch, *Conscientious Refusals* at 165. Lynch’s proposal addresses only individual, not institutional, refusals.

¹¹⁰ Luke Goodrich, *The Health Care and Conscience Debate*, 12 Engage 121, 123 (June 2011).

¹¹¹ According to Weitz, there are only 18,000 places left in the country where abortions are provided, and there are 1.2 million abortions each year; see also Jones RK, Kooistra K. “Abortion incidence and access to services in the United States, 2008.” *Perspectives on sexual and reproductive health* (2011), 43: 41-50.

conscience in the former context is a different matter than protecting them in the latter, they say.

In any case, how should we define inconvenience? And, in true cases of patient inconvenience, should conscience rights always prevail?

Professor Kent Greenawalt has proposed that “substantial inconvenience should be the test” in certain cases, something like driving more than thirty miles to another pharmacy. In Greenawalt’s eyes, “consumers should not have to undergo substantial inconvenience to satisfy a state-created legal right of conscience.” He says this standard would not necessarily be the right one for cases involving abortion, however. “[I]f women are still able to get abortions, an inconvenience of this magnitude should not override the conviction of nurses that their participation assists in murder.”¹¹²

Some say conscience rights should not prevail even in certain cases involving mere patient inconvenience. For example, while the ACLU asserts that institutions should strive to accommodate their employees’ religious needs, it has argued that pharmacists’ objections to providing certain services should be honored only when the patient could receive the requested service or device in a timely manner at the same pharmacy.¹¹³ Apparently, this position would hold even if a patient could walk across the street and get her prescription filled immediately thereafter. The ACLU says its position is based on the fact that “[t]he pharmacy is a state-regulated business that supplies medication to the general public and serves people of diverse backgrounds and faiths: it operates in the public world and should play by public rules.”¹¹⁴

In reaching this conclusion, the ACLU argues that doing otherwise would confer a right to impose one’s religious views on others and that our society historically has not viewed separate service as an answer to discrimination. For example, the ACLU points to the fact that the Civil Rights Act did not provide religious exemptions for restaurants and hotels when these establishments objected to nondiscrimination rules and nearby restaurants and hotels served clients regardless of race. This principle should apply to laws and regulations governing access to medical services as well, the ACLU says. Thus, the ACLU would draw a line here that is unrelated to access concerns.¹¹⁵ Others, however, reject this point of view, saying there are large and important differences between racial discrimination based

¹¹² Greenawalt, *Refusals of Conscience* at 22.

¹¹³ ACLU Reproductive Freedom Project, *Religious Refusals and Reproductive Rights Accessing Birth Control at the Pharmacy* (2007) at <http://www.aclu.org/reproductive-freedom/religious-refusals-and-reproductive-rights-accessing-birth-control-pharmacy>.

¹¹⁴ *Id.* at 5.

¹¹⁵ ACLU Reproductive Freedom Project, *Religious Refusals and Reproductive Rights* (2002) at <http://www.aclu.org/reproductive-freedom/religious-refusals-and-reproductive-rights-report>.

on religious reasons and conscientious refusal to provide certain health services to any patient or client.

Finally, the fact that a health care provider receives some form of government aid matters to some when deciding whether to honor conscientious objections.¹¹⁶ A provider should not be able to tailor service offerings based on religious beliefs if the provider receives government funds, they say. In other words, when government funds subsidize a hospital, clinic, or practice group, taxpayers usually ought not be denied health services there due to a provider's religious objections. To do otherwise would diminish the religious freedom of the patients who do not share the religious convictions of the provider. Some government funds come with explicit conditions requiring the provision of particular health care services. If a provider objects to these conditions, the provider need not accept government aid, they argue.¹¹⁷

This was precisely the argument that was defeated with the passage of laws like the Church Amendment, others say.¹¹⁸ Government funds should not be used as a tool to defeat conscientious objections; instead, they should be used to protect such objections. It is almost impossible for a health care provider to operate today without accepting some form of government funding, even if it is only reimbursements from Medicare and Medicaid. It is wrong and unlawful, they say, to place conditions on such aid that would pressure providers into forsaking their religious convictions.¹¹⁹

What sort of rules should govern disclosures of conscientious objections, information regarding alternative providers, and referrals to other providers?

The consensus view is that health care providers with religious or moral objections to the provision of certain services should fully disclose those objections to patients or prospective patients at the earliest possible moment and do so in a conspicuous and meaningful way.¹²⁰ The form such disclosures should take, however, is a matter of some debate.

¹¹⁶ While some would count tax expenditures and even state licenses as government aid, others would limit this argument to cases involving more substantial forms of government assistance like grants.

¹¹⁷ Some of these arguments are beginning to play out in the social service setting as well. See Jerry Markon, *Health, abortion issues split Obama administration and Catholic groups*, The Washington Post (October 31, 2011).

¹¹⁸ See *supra* 17-20.

¹¹⁹ According to University of St. Thomas Law School Professor Robert K. Vischer, the danger to be avoided here is that, "[e]specially in fields where government funding utterly shapes the marketplace (education, health care), [the conditions that follow government funds could] easily render the entire provider landscape morally homogenous." Brookings discussion.

¹²⁰ Some state laws contain such disclosure requirements. For example, California law states: "Any . . . facility or clinic that does not permit the performance of abortions on its premises shall post notice of that proscription in an area of the facility or clinic that is open to patients and prospective

In the case of hospitals, is placing a disclaimer on entrance forms and a prominent sign in the lobby sufficient?¹²¹ What if the disclaimer relates to circumstances the average patient would have little, if any, expectation of encountering during his or her hospital stay? Bioethicist Lori Freedman explains her concern: “Patients entering a Catholic-owned hospital may be aware that abortion services are not available there, but few prenatal patients conceive of themselves as potential abortion patients and therefore they are not aware of the risks involved in being treated there; these include delays in care and in being transported to another hospital during miscarriage, which may adversely affect the patient’s physical and psychological well-being.”¹²²

Most also agree that providers should promptly offer general information to patients about service alternatives. On the other hand, requiring conscientious refusers to make specific referrals is deeply divisive. ACOG’s policies require such referrals and argue that “[r]eferral to another provider need not be conceptualized as a repudiation or compromise of one’s own values, but instead can be seen as an acknowledgement of both the widespread and thoughtful disagreement among physicians and society at large and the moral sincerity of others with whom one disagrees.”¹²³ The American Pharmacists Association has a similar policy and view.¹²⁴

Some strenuously disagree, however, arguing that referrals involve some association or cooperation with the objectionable act. “Referring generally involves making the deed part of one’s own project,” theologian and bioethicist Gilbert Meilaender says. Thus, Meilaender counsels, conscientious objectors should not be required to make such referrals.¹²⁵

Still others acknowledge such reservations as legitimate, but nonetheless insist referrals are often necessary. For example, bioethicist Holly Fernandez Lynch says that, “despite valid concerns of complicity, the refusing physician likely has a responsibility to help patients connect with those alternate providers through direct referrals, or potentially through indirect referrals to some higher-level source of

admittees.” Cal. Health & Safety Code Section 123420(c). See also Neb Rev. Stat. 28-337 and Or. Rev. Stat. Section 435.475.

¹²¹ Professors Julie Cantor and Ken Baum have provided specific advice on disclosures for pharmacies that do not stock emergency contraception. “At the very least,” Cantor and Baum say, these pharmacies “should be a prominently displayed sign that says, ‘We do not provide emergency contraception. Please call Planned Parenthood at 800-230-PLAN (7526) or visit the Emergency Contraception Web site at www.not-2-late.com for assistance.’” Cantor and Baum, *The Limits of Conscientious Objection* at 2011.

¹²² Lori Freedman, *When There’s a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 American Journal of Public Health 1, 4 (October 2008).

¹²³ ACOG, *The Limits of Conscientious Refusal* at 2.

¹²⁴ Cantor and Baum, *The Limits of Conscientious Objection* at 2011.

¹²⁵ Brookings discussion.

information, such as state licensing board or professional association.”¹²⁶ At least in some cases, conscientious objectors who would refuse to make direct referrals might not object to making indirect referrals.

It is widely agreed that a right to conscientious objection does not include a right to proselytize, harass, or condemn patients. Patients’ moral autonomy and dignity, including their own conscientious judgments, must be respected.

At the same time, some argue that a health care provider should have substantial latitude to share the nature of his or her convictions with the patient. The “[m]edical encounter is a moral encounter,” Meilaender says.¹²⁷

Others, however, point to concerns like the power differential inherent in the doctor-patient relationship and reject the notion of the medical encounter as simply one of many moral encounters.¹²⁸ “The health care encounter is a *unique* moral encounter,” Dr. Laurie Zoloth says, “for it involves a particular and intimate response to a particular human body, one with urgent needs, sufferings, fragilities, and failures.” She goes on to point out that “[t]he objector, who bears none of these sufferings, and who controls the means to answer these needs, has a distinct duty of response, and owes attention to this moral duty as well.”¹²⁹ Rabbi David Saperstein adds: “It’s one thing to say that in the privacy of a doctor’s office the doctor may offer his or her moral perspective on the ethics of medical procedures. But it’s another to say a pharmacist could lecture a woman asking for birth control in front of others.” Particularly because so many of these issues involve sex and reproductive health, they raise real concerns about creating embarrassment for the patient, Saperstein warns.¹³⁰

¹²⁶ Greenawalt, *Conscientious Refusals* at 167.

¹²⁷ Brookings discussion.

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *Id.*

CONCLUSION: SUGGESTIONS FOR POLICYMAKERS

It would be neither possible nor productive to conclude this report with detailed recommendations on the disputed issues we have discussed. We do have some broader suggestions, however, that we believe would shift the debate onto a more productive path.

First, *don't spend much time looking for bright-line solutions*. The differences of principle cut too deep, and proposed solutions that completely satisfy the demands of any one party are bound to evoke passionate dissents from the others. In most cases, the aroused losers will be able to fight rear-guard actions through Congress, the courts, or the regulatory process, thwarting an effective settlement.

Second, *accept the presumption of non-discrimination and equal treatment of individuals as a basis for public policy*. The default position for policymakers should be that the focus is on needs rather than persons and that statements of the form "Because of your lifestyle or sexual orientation, I refuse to provide you with a medical service that I would provide others" are inherently suspect. To be sure, there are circumstances in which physicians may be justified in distinguishing between patients based on status considerations. For example, a long history of alcoholism may disqualify an individual otherwise eligible to receive a liver transplant. But these cases are the exception, and medical providers ought to be required to discharge a heavy burden of proof.

Third, *whenever possible, move the debate from principles to specifics*. In many cases, a fact-rich description of what is at stake in a particular controversy will make some proposed resolutions seem fairer and more reasonable than others. For example, it is one thing to require nurses to participate in abortions, quite another to ask them to perform routine administrative duties tangentially related to the procedure.

Fourth, *distinguish between what matters and what doesn't*. There is a reason why concepts such as a substantial or undue burden play an important role in law and regulation. No rule is purely neutral in its impact on everyone it touches. Some are advantaged, some disadvantaged. The question is how much. It is one thing when a pharmacist's conscience makes customers seeking the morning-after pill cross the street, quite another when it forces them to drive hours. In the first case, the burden is minimal; in the second, excessive. Reasonable people will see the difference.

Fifth, *take the logic of institutions seriously*. Particular roles typically carry with them an ensemble of responsibilities, and it would make no sense to occupy the role while claiming a broad exemption from those responsibilities. Many

accommodations may be possible and justified. At some point, however, employers are entitled to say, “You’ll have to choose between your conscientious objections and your job.” Conversely, there is a distinction between the responsibility of individual health professionals and of the profession as a whole. The profession has an obligation to do everything it can to meet the needs of patients; not so with individual practitioners. As bioethicist Holly Fernandez Lynch has noted, by raising mandates from the individual to the institutional level, collisions between the conscience of providers and the needs of patients can be minimized though not eliminated.

Sixth, recognize that the right of conscience includes a right to decline to participate in the delivery of services, but it does not include a right to attempt to block a patient’s access to those services. There is a difference between refusals to participate in delivering a service and attempts to block a patient from accessing a service. This line is not always bright, but most can agree not only on the principle but also on some applications of it. If a pharmacist tears up a prescription for the morning-after pill, for example, that moves far beyond refraining from participating in the delivery of a service and qualifies as an effort to block access to that service. Health care workers may sometimes refuse to provide services, but they should not be permitted to create roadblocks that prevent patients from accessing those services.

Seventh, make early and full disclosure of conscientious objections to the patient the rule, as well as complete and prompt disclosure of available alternative for service. There is widespread agreement about the need for early and full disclosure regarding the conscientious objections of health care providers and available alternatives for service. It is true that the issue of making referrals is fraught, but doctor-to-doctor referrals are not the only way to share information. Most agree that conscientious objectors have a duty to notify patients about their concerns and that these patients should be provided with prompt and complete information about service alternatives. As Professor Robin Fretwell Wilson has argued, “information-forcing” rules may do a great deal to minimize conflicts in this area, particularly given the rapid development of information technologies.¹³¹

Eighth, recognize that the right to conscientious objection does not encompass a right to proselytize, condemn, or harass patients. Patients’ moral autonomy and dignity, including their own conscientious judgments, must be respected. A right to object to participating in a procedure for moral or religious reasons does not justify proselytizing or condemnation of patients. Just as a provider seeks respect for his or her conscience, the provider should honor the consciences of patients. While there are differences over how much information a provider may share with a patient about the provider’s conscientious objection and how the provider should do

¹³¹ Robin Fretwell Wilson, “The Limits of Conscience: Moral Clashes over Deeply Divisive Healthcare Procedures,” *American Journal of Law & Medicine*, 34 (2008): 61.

so, there is agreement that the patients' moral autonomy and dignity should be respected.

Ninth, *acknowledge that defending the right of conscientious objection isn't the same as defending the merits of the objection itself.* The culture war over abortion certainly affects the conscience debate, but it continues to be possible, and many believe, desirable, to defend another's conscientious objection to participating in the delivery of a health care service while disagreeing with the objectors' concerns about that service. Americans have a long and rich history of defending each others' rights of conscience even as they argue with one another about the merits of the underlying objections. Recognizing a right of conscientious objection is not the same as saying it should prevail in all cases, but a failure to value the right of conscience in one context surely threatens that right in other contexts.

Tenth, *recognize that moral diversity in the health care profession is a public good.* Preserving moral diversity within the health care profession helps to guard against the tragic ethical mistakes that often occur when dissent is silenced.¹³² Of course, all points of view on all issues of medical ethics are not equally valued. To cite an extreme example, a person who believes physical abuse of children is morally acceptable would not be a fit health care worker. There are many other issues, however, where reasonable minds may come to different moral conclusions, and it is helpful for the medical profession to protect the right to differ on these issues. Bioethicist Holly Fernandez Lynch explains:

[T]he driving force and strongest argument for retaining room for moral refusers in the profession is the fact that many of the issues facing physicians raise metaphysical questions entirely immune to empirical testing or any other comprehensive doctrine for distinguishing right from wrong. ... [W]e benefit from maintaining diverse viewpoints, excluding only arguments that are entirely illogical, for the ensuing debate will help siphon out the most accurate version of moral truth as errors are revealed and persuasive arguments are strengthened through their collision with error.¹³³

There are differences about exactly how to value moral diversity on issues of medical ethics. Most agree, however, that maintaining the freedom to differ on many moral issues within the medical profession is a good that should be protected. Many would add that this freedom is part of a larger good—that of a free and diverse civil society whose institutions help shape individuals and provide alternatives to publicly defined conceptions of the human and civic good.

¹³² Holly Fernandez Lynch, *Conflicts of Conscience in Health Care: An Institutional Compromise* at 84-85

¹³³ *Id.* at 84-85

Finally, *always look for ways of including competing principles and divergent interests*. Policymaking takes place on the level of symbolism and emotion as well as of calculation and impact. Totally denying the claims of one party and legislating based entirely on the core arguments of the other sends a powerful message: your moral perceptions don't count, and your core interests don't matter. That is rarely the formula for productive and sustainable policymaking in a diverse democracy.

Efforts to strike these balances often will meet with more approval than expected. While it is sometimes suggested that there are two warring sides on these matters, both seeking to win zero-sum games, the truth is most involved in the debate believe that both protecting the rights of conscience and securing access to health care services are legitimate and important goals that we should seek to harmonize. Even when these sides cannot agree about the circumstances in which conscience-based claims should be honored and those in which access must take priority, they typically agree that both principles are worthy of respect. And that is the common ground on which we have tried to build.

A C K N O W L E D G E M E N T S

This report would not have been possible without the support and guidance of Sheila Davaney, and for that its authors are most appreciative. The authors would like to thank our colleague E.J. Dionne for his insightful contribution to organizing and conducting the Brookings discussion, and we wish to offer our deep gratitude to Korin Davis for her work on this project. Korin has expertly led the project from start to finish, and she has served as an excellent editor and colleague in this work. In addition, we would like to thank Raul Beke and Ross Tilchin for their detailed and comprehensive work in fact-checking the paper and verifying citations, Christine Jacobs and Stephanie Dahle for their help with publication and dissemination, and Emily Luken for all her assistance with this work. Despite their invaluable contributions, none of these recipients of our gratitude bears ultimate responsibility for, or necessarily endorses, the views contained in this report.

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